



# AHLTA and Data Entry A Provider's Perspective

## Data Quality Management Course

# AHLTA and Data Entry - A Provider's Perspective

## Objectives

- A review of how an average provider views coded data and metrics
- Demonstrate issues regarding data entry into our outpatient systems
  - Clinical-centric data
  - Business-centric data
- Understand difference between “documentation” and “coding” to see why some data errors may arise



Metrics drive behavior



## Metrics in Action

- Commander: “I want my facility to get as many Relative Value Units (RVUs) as we should to reflect the hard work we are doing”
- Business Office: “Facility RVUs is a product of number of encounters times the RVUs/encounter. We should increase the RVUs/encounter to increase facility RVUs”
- Clinic Chief: “We have a lot of t-cons that are worth very few RVUs, and that brings our RVU/encounter down. So admin-out all of the t-cons so that our RVU/encounter goes up”

This occurred at a facility I visited. The focus in a clinic on a single metric (RVU/Encounter) drove a behavior that the Commander *never* meant to have happen!



# Common Provider Metrics

- Empanelment
- Number of patients seen each day/week/month
- Number of no-shows
- Patient Satisfaction
- HEDIS compliance
- RVUs/visit
- RVUs/day

As a “lowly” provider, there are relatively few that I can directly impact.



## Clinical Data



# Clinical Data

In AHLTA, clinical data can be separated into a few broad categories:

- Data from the S/O module (subjective/objective data)
- Data from A/P Module (diagnoses, procedure codes, orders)
- Data from free-text areas of the AHLTA encounter
- Data from everything else
  - Vitals
  - Questionnaires
  - Results for labs, meds, radiology
  - Etc, etc



# Clinical Data

## ■ S/O notes = Medcin

**Past, Social and Family Hx** have 2 potential levels (pertinent and complete). A pertinent contains at least 1 type of history (Past, Social or Family) -> (99214)  
A complete for a new patient requires all 3 types of history (Past, Social and Family) to be documented. None required for a 99213.

**Past Medical History (1)** Note: Any 1 of the 3 history items in burgundy will give 1 credit towards Past Hx

☒ **Current Medications** : Current medications reviewed and reconciled.

☒ **Medical History** : reviewed

☒ **Surgical History** : reviewed

☒ Medication list reviewed with patient, reconciliation completed, and list given to patient.

☒ Noncompliance With Meds ☒ Hx of Cancer

☒ **Review of Immunizations** : up to date

**Information Source:** ☒ Patient ☐ Other:

**Branch of Service:** ☒ USA ☐ USN ☐ USAF ☐ USMC **Status:** ☒ Active Duty ☐ Reservist ☐ Retired

☒ Visit Is Deployment-related ☐ If YES, please type in the Location of Deployment

☒ Visit Is GWOT-related ☐ NOTE: Use for resource management tracking of visits.

**Learning and Understanding** ☒ Learning Disability (barriers to learning)

**Vitamins/Herbals/OTCs** ☒ Taking Vitamin Supplements ☐ Taking OTC Medications ☐

**Quick Physical Exam Entry for Normal Findings**

<b>Vital Signs (1)</b>	<input checked="" type="checkbox"/> Reviewed	<input checked="" type="checkbox"/> T	<input checked="" type="checkbox"/> P	<input checked="" type="checkbox"/> R	<input checked="" type="checkbox"/> SBP
<b>Constitutional (1)</b>	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N WD	<input type="checkbox"/> Y <input type="checkbox"/> N WN	<input type="checkbox"/> Y <input type="checkbox"/> N NAD	<input type="checkbox"/>
<b>Gen Appearance (1)</b>	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Oriented x3	- Credits under Psychiatric section -		
<b>Eyes (2)</b>	<input checked="" type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N PERRL	<input type="checkbox"/> A <input type="checkbox"/> N Sclera	<input type="checkbox"/> A <input type="checkbox"/> N Conjunctiva	<input type="checkbox"/>
<b>ENT (2)</b>	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> A <input type="checkbox"/> N TMs	<input type="checkbox"/> A <input type="checkbox"/> N Posterior Pharyngeal Wall		

Thyroid ☐  
Cervical ☐ ☒ Submandibular ☐  
Wheezing ☐ ☒ Rales ☐  
Murmur ☐ ☒ Rub ☐  
S2 ☐ ☒ S3 ☐  
ND ☐ ☒ BS Decreased ☐  
Spleen ☐ ☒ Liver ☐  
Testes ☐ ☒ Prostate ☐  
Vagina ☐ ☒ Cervix ☐  
Adnexae ☐ ☒ CMT ☐  
Palpation ☐ ☒ Axillary Nodes Enlarged ☐  
Bruising ☐  
DTRs ☐ ☒ Balance ☐  
Sensation ☐ ☒ Cerebellar ☐  
Affect ☐  
under Cardiovascular section -

**S/O Text is \*always\* Medcin**

☒ vomiting  
☒ abdominal pain  
☒ diarrhea





## Observation #2

Providers aren't willing to spend a lot of time  
looking  
for the “right” term



# Clinical Data

Because providers aren't willing to spend a lot of time finding the exact Medcin term, anyone viewing the data shouldn't expect to find much specificity

Example:

- Paper note: "Patient had mild inspiratory wheezing in the left lower lung field"
- "Perfect" Medcin note: "Mild inspiratory wheezing. Wheezing was heard on the left at the base". 10+ mouse clicks
- Realistic Medcin note: "Wheezing was heard *in the left lower lung field with inspiration.*"

*(All text in red is free-text)*



# Clinical Data

- Since providers won't spend time looking for terms, they will use the ones they *can* find easily **all** the time.
- If there is a term/concept that needs to be captured, it needs to be placed in a template that is being used
- Only AIM forms have “guaranteed” stability
- No system mechanism available to “mandate” any usage of the S/O module



# Example of current Medcin use

**Past, Social and Family Hx** have 2 potential levels (pertinent and complete). A pertinent contains at least 1 type of history. A complete for a new patient requires all 3 types of history (Past, Social **and** Family) to be documented. None re

**Past Medical History (1)** Note: Any 1 of the 3 history items in burgundy will give 1 credit towards Past Hx

<input checked="" type="checkbox"/> <b>Current Medications</b> : Current medications reviewed and reconciled.  <input checked="" type="checkbox"/> Medication list reviewed with patient, reconciliation completed, and list given to patient. <input checked="" type="checkbox"/> <input type="checkbox"/> Noncompliance With Meds	<input checked="" type="checkbox"/> <b>Medical History</b> : reviewed  <input checked="" type="checkbox"/> <input type="checkbox"/> Hx of Cancer	<input checked="" type="checkbox"/> <b>Surgical History</b> : reviewed  <input checked="" type="checkbox"/> <b>Review of Immunizations</b> : up to date
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Information Source:  ☒ Patient ☐ Other:

- The “Current Medications” term is the same in all AMEDD AIM Forms
- There are queries that are run to check compliance with filling that box



## Observation #3

Providers care considerably more about  
the  
quality of their documentation than they  
do  
about the codes generated



# Clinical Data

- Are diagnoses (i.e. the ICD-9 codes) in AHLTA clinical data or business data?
- Is there a difference?
- Is there a 1:1 correspondence between diagnoses in a paper chart and diagnoses in AHLTA?



# Clinical Data

- Diagnoses in the paper world
  - Providers could list diagnoses in any order
  - They could call a diagnosis whatever they wanted to
  - Coders never told a provider their diagnosis was “wrong”
  - Codes reflected what was in the documentation
  
- Today in AHLTA
  - There are rules for the ordering of diagnoses
    - What must be first, what must be one of the first 4, etc
  - Providers are limited on what they can directly call something
    - They aren't limited to the ICD-9 text for what is printed
    - What's available isn't as robust as options with written notes
  - Providers are told that their documentation is wrong
    - They are told their code is wrong, but the code *is* the documentation



# Clinical Data

Scenario #1: An 8 month old child is seen today because the doctor saw fluid in the middle ear a month ago and wanted to make sure it cleared after an infection. On exam today there is no fluid seen.

Paper chart: Assessment – s/p  $\overline{\text{OM}}$  c effusion, now resolved. F/U at WCC in 1 month or PRN.





## Scenario #1 (cont)

AHLTA Note:

### 1. Otitis Media

Comments: Effusion has resolved

### 1. Visit for: Follow-up Exam

Comments: s/p om w effusion, resolved

Added Frustration: The provider gets a different list of codes depending on if they search for “followup”, “follow up” or “follow-up”



Scenario #2: 22 year old type 1 diabetic is 16 weeks pregnant and is coming in for a routine pre-natal visit. During the visit she complains of discharge and a GC probe is collected. It comes back from the lab positive for a Sexually Transmitted Disease.

- What do the coding rules say needs to be coded?
- What would the provider have written in the paper world?
- What is the incentive for the providers to do the extra work required to code above and beyond their documentation needs?



## Business Data



# Business Data

- There are three categories of codes that providers consider to be “business data”
  - ICD-9/10 codes (discussed previously)
  - CPT/HCPCS codes
  - E&M Codes

In the provider's eyes, anything else is a very distant fourth



## Procedure (or CPT) Codes

- Picked from Medcin terms, with a “many to one” mapping to CPT codes
  - E.g. both “Electrocardiogram” and “ECG 12-lead with interpretation and report” map to code 93000
  - The CPT code doesn’t end up on the note
- Providers \*can\* search for exact CPT codes if known
- Nearly all providers use templates or favorites lists to store their commonly used ones



## Back to observation #2

“Providers aren’t willing to spend a lot of time looking for the right term”

- Providers will use what they can easily find, so once a code is in a template it is much more likely to be commonly used, *even if it’s the wrong code!*
- Work with the AHLTA training staff at your facility to help providers “clean up” the codes they shouldn’t be using out of their templates & favorites lists



## HCPCS Codes

- Observation #1 - “Metrics drive behavior”
- If there are no RVUs associated with a code, providers will not be *internally* motivated to capture it



## Evaluation and Management (i.e. E&M) codes

### ■ Observation #1

### ■ Background

- E&M codes are a subset of all CPT codes that the DoD breaks out separate
- For many physicians, the vast majority of their RVUs come from their E&M codes
- AHLTA has an E&M calculator that works pretty well, provided it has data it understands
- AHLTA's E&M calculator doesn't include DoD-specific coding guidance (e.g. it doesn't force Medical Decision Making as a component for established patients)
- AHLTA's coding system has a number of "quirks"





## Issues with the AHLTA Coding Calculator

- It can only use the 97 coding guidelines
- It can only count what it can “count”
  - The coding calculator can’t account for any data that is free-text
- It doesn’t ‘care’ about the nature of the presenting problem
- It does look at things a DoD coder is told not to look at



# Business Data

So what do providers do about their E&M codes?

- See “Observation #1”
- They would rather error on the side of “too high” than “too low”
- They pick the code they think is “right”
  - Especially if they have a lot of free text
- They click the “greater than 50% of time spent counseling and coordinating care” checkbox
  - Especially if they don’t want to write more free text



So how accurate is the coding calculator in AHLTA?

- Answer: “Great! As long as it has stuff to count.”
- Reality:
  - Most providers always override the suggested E&M code (see “Observation #1”)
  - Providers are much more likely to be praised for high RVUs than they are to be penalized for inaccurate coding (this also affects CPT coding)



# Some Final Thoughts

- “Metrics Drive Behavior”
  - If a clinic looks at metrics for RVU generation (and trust me, they do) but they don’t care about (or even see) metrics on coding accuracy, it is unlikely that you will get providers to change current coding habits.
- “Providers aren’t willing to spend a lot of time looking for the ‘right’ term”
  - When looking at either clinical or business data, don’t expect a lot of specificity in the coded data. Providers want to finish their note, and if they can’t find something quickly they’ll pick anything and move on.
- “Provider care considerably more about the quality of their documentation than they do about the codes generated”
  - Proper training can help enable providers to generate quality notes that still provide the structured data needed

